AccuVision Optical **Patient History Form** ❒ Verified *(office use only)*

2161 Main Street Dunedin, FL 34698 - Phone 727-734-8843

Last Name_____ **First Name**_____ **Middle Initial**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Home Phone_____ **Work Phone**_____ **Cell Phone**_____ ❒ Do not text

Email_____ **Sex** ❒ M ❒ F **Birthdate**_____-_____-_____ **Age**_____

Social Security # _____-_____-_____ **Marital Status:** ❒ Married ❒ Single ❒ Divorced ❒ Widowed

Employment Status_____ **Employer**_____ **Occupation**_____

How did you hear about us? ❒ Insurance ❒ Referred By?_____ ❒ Internet_____
❒ Yellow Pages ❒ Walk-In

Race ❒ White ❒ African American ❒ Hispanic ❒ Asian ❒ Native American ❒ Other_____

Preference ❒ Email ❒ Postal Mail ❒ Telephone **Vision Insurance** ❒ No ❒ Yes (name)_____

Do you have a Flexible Spending or Health Savings Account? ❒ Yes ❒ No *(Rx sunglasses are eligible!)*

Emergency Contact_____ **Phone**_____ **Relationship**_____

Sports/Hobbies_____

Eye doctors can bill your exam for **VISION** needs (glasses/contacts), or for **MEDICAL** needs (eye problems not related to glasses.) The **MAIN reason** you have come in today dictates the type of exam, and whether we must bill your **vision insurance** (VSP, EyeMed, VCP, etc.) or **medical insurance** (Medicare, BC/BS, etc.)

Check only ONE:

❒ I'm here mainly for a glasses or contact lens exam. **Vision insurance** or discounts may be used if AccuVision Optical takes my plan, or I will pay for the visit myself. (My eye health will still be evaluated for disease.)

❒ I'm here mainly for a medical concern about my eyes, like red or dry eyes, floaters or glare. **Medical insurance** may be filed, if AccuVision Optical takes my plan, or I will pay for the visit myself. (My glasses or contact lens Rx can still be provided. Note: With some insurance i.e. Medicare, there is a fee for this service.)

Primary Physician Name/Phone_____ **Approx. Date of Last Physical Exam**_____

Glasses: **Do you currently wear glasses?** ❒ Yes ❒ No ***(If yes, check all that apply below)***

❒ Distance ❒ Computer ❒ Multifocal ❒ Near ❒ OTC Readers ❒ Sunglasses

Are you planning on getting a pair of glasses and/or sunglasses today? ❒ Yes ❒ No ❒ Maybe

Contacts: Do you wear Contact Lenses?

❒ Yes ➔ Brand_____ Powers_____ Base Curve_____

Average time worn? Hours Per Day_____ Days Per Month_____

Do you sleep in your contact lenses? ❒ Yes ❒ No **If Yes, how many nights in a row?**_____

What brand of solution do you use? ❒ Biotrue ❒Generic ❒ Optifree ❒Renu ❒Other_____

Do you have a current pair of glasses in case of trouble with your contacts? ❒ Yes ❒ No

❒ No ➔ **Are you interested?** ❒ Yes ❒ No

LASIK: Are you interested in learning about surgical/laser correction? ❒ Yes ❒ No ❒ **Prior LASIK** Date_____

Assignment of Benefits: I authorize release of any medical or other information needed for this or related insurance claims. I assign any benefits payable to Dr. Tupps or AccuVision Optical. I understand that I am responsible for payment of any balance not covered by insurance.

Payments: All required payments, co-payments and deductibles are due in full at the time the services are rendered or materials are provided, unless specific financial arrangements have been made prior to your appointment.

Notice of HIPAA Privacy Practices: I have been offered a copy of AccuVision Optical's Notice of Privacy Practices, effective April, 14, 2003.

Signature: I have read and understand the terms and conditions outlined above, and I hereby certify that the information I provided is accurate and true.

X_____ (Signature of Patient or Guardian) **Date:** _____

PATIENT EYE HISTORY

Do you currently have any of these issues? Or, have you had any of these issues in the past?

(Check all that apply)	Currently	In the Past
Allergy/Hayfever	❒	❒
Blurry Vision With Glasses/CLs	❒	❒
Corneal Abrasion	❒	❒
Crossed Eye/Eye Turn	❒	❒
Double Vision (2 Images)	❒	❒
Dry Eye	❒	❒
Eye Fatigue/Tired Eyes	❒	❒
Eye Infections	❒	❒
Eye Injury/Trauma	❒	❒
Flashes of Light	❒	❒
Floaters/Spots	❒	❒
Foreign Body in eye	❒	❒
Headaches (Frequent)	❒	❒
Itchy/Burning Eyes	❒	❒
Pain/Irritation	❒	❒
Red Eye	❒	❒
Sensitivity To Light	❒	❒
Vision Loss	❒	❒
Watery Eyes	❒	❒

Other Eye Problems_____

_____

FAMILY MEDICAL / EYE HISTORY *(Check all that apply)*

Have you or a blood relative been diagnosed?

	Self	***Family History - Relationship to You***
Blindness	❒	_____
Cancer	❒	_____
Cataracts	❒	_____
Cornea Problems	❒	_____
Eye Turn/Lazy Eye	❒	_____
Glaucoma	❒	_____
Macular Degen.	❒	_____
Retinal Problems	❒	_____
Heart Disease	❒	_____
Diabetes	❒	_____

Other (Inheritable)_____

Do you use? ❒ Tobacco ❒ Alcohol ❒ Other Substances

PATIENT MEDICAL HISTORY

Height_____ **Weight**_____ **Last BP**_____/_____

Current Medications (list ALL Rx, over the counter, eye drops & vitamins) _____

_____

_____

_____

Allergies to Medications ❒ None ❒ Penicillin ❒ Sulfa

❒ Other_____

_____

Are you pregnant? ❒ Yes ❒ No **Nursing?** ❒ Yes ❒ No

REVIEW OF SYSTEMS

Check <u>&/OR LIST OTHER</u> problems with any of these systems.

Allergy

_____

Cardiovascular (❒ high BP, ❒ cholesterol, ❒ heart disease…)

_____

Constitutional (❒ appetite, ❒ sleep, ❒ thirst, ❒ fatigue…)

_____

Endocrine (❒ diabetes, ❒ thyroid…)

_____

Gastrointestinal (❒ acid reflux, ❒ ulcer, ❒ IBS…)

_____

Genitourinary (❒ kidney disease, ❒menopausal ❒ prostate…)

_____

Head (❒ headache, ❒ ear/nose/throat, ❒ sinus…)

_____

Hematologic/Lymph (❒ blood disorders, ❒ leukemia…)

_____

Immunologic (❒ serious infection, ❒ HIV, ❒ hepatitis…)

_____

Integumentary (❒ skin trouble, ❒ rosacea, ❒ lupus...)

_____

Musculoskeletal (❒ rheumatoid arthritis, ❒ osteoporosis…)

_____

Neurological (❒ Bell's palsy, ❒ MS, ❒ Parkinson's…)

_____

Psychiatric (❒ depression, ❒ Alzheimer's, ❒ ADD, ❒ anxiety…)

_____

Respiratory (❒ asthma, ❒ lung disease…)

_____

Significant Surgeries/Hospitalizations and year?_____

_____

_____

_____